

When bed isn't a safe haven


BY JOAN FERLO TODD, RN

A 68-YEAR-OLD patient who was dysphasic and paralyzed on one side after a stroke somehow slid into a gap between her mattress and side rail. Unable to pull herself up or call out, she strangled on the side rail.

A bed system includes the frame and mattress, side rails, headboard, footboard, and accessories. Not all components are compatible, and a bad mix can increase the risk of patient entrapment. From 1985 to 2001, the Food and Drug Administration (FDA) received 479 reports of patients becoming entrapped in hospital beds; 297 of these died. They'd been trapped in openings within or between side rails, between side rails and the mattress, or between side rails and the headboard or footboard.

Patients who are frail, elderly, or have uncontrolled body movement or difficulty with memory have the greatest risk of entrapment. Here's how to reduce the risk:

- Assess each patient's abilities and follow your facility's policy to determine if side rails are required.
- If they are, make sure that their design and their relationship to other bed components don't increase the risk of entrapment. For example, bars within the side rail should be closely spaced to prevent the patient's head from entering.
- Regularly check to make sure side rails work correctly.
- Make sure that the mattress is the appropriate size for the bed frame and that the space between the mattress and the side rails is small enough to prevent entrapment.
- If a patient becomes entrapped (even briefly—with or without injury), immediately reevaluate his needs and his bed system. Intervene as necessary to prevent another event.
- Ask manufacturers about bed equipment compatibility, appropriateness for the care setting, and the intended bed use.
- Inspect, evaluate, maintain, and upgrade bed systems to identify and remove unsafe equipment.

The FDA-led Hospital Bed Safety Workgroup has developed guidelines for hospital beds. Within the next few months, look for **Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings** and visit the FDA's Web site at <http://www.fda.gov/cdrh/beds/>. 

Although you need to support the adverse event-reporting policy of your health care facility, you may voluntarily report a medical device that doesn't perform as intended by calling MedWatch at 1-800-FDA-1088 (fax. 1-800-FDA-0178). The opinions and statements in this article are those of the author and may not reflect the view of the Department of Health and Human Services. Beverly Albrecht Gallaresi, RN, BS, MPH, coordinates Device Safety.

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